

DESCRIPTION OF PROGRAMS/SERVICES

Clinical Units:

Mid-Missouri Mental Health Center's clinical services are divided into two basic services: adult and child. Members of the clinical staff are, by and large, attached to these services. The organizational relationships of each of the Center's programs (including channels of staff communication, responsibility, and authority as well as supervisory relationships) are outlined in the Staff Composition subsection and Organizational Charts.

Children's Inpatient Service:

The Children's Inpatient Unit provides inpatient and partial hospitalization services to children ages 6 through 17 years. The space is physically divided into a Preadolescent and an Adolescent side with five beds each. The unit is designed to provide inpatient treatment for ten and partial hospitalization for four patients. The primary focus is on providing acute hospital services to children at immediate risk of danger to self or others due to a psychiatric disorder. However, because Mid-Missouri Mental Health Center is part of the "safety net", occasionally, in unique situations, the unit provides intermediate length care or meets other patient needs.

Hours of Operation.

The unit operates 24 hours a day, 7 days a week with nursing and medical/psychiatric coverage. Other professional staff generally work 8:00 a.m. to 4:30 p.m., Monday through Friday. On an as needed basis, professional staff work outside of these hours to accommodate patient families' schedules. In addition, Therapeutic Recreation staff regularly provide services during the evenings and on weekends. Intake and screening of individuals walking into the building for an unscheduled crisis screening are available 24 hours a day.

Screening, Intake and Admission Procedures.

The preferred procedure is for a child to be screened by the Administrative Agent, with the Administrative Agent determining whether or not psychiatric hospitalization or partial hospitalization is needed. The philosophy is that children are best served in the least restrictive setting possible and should receive community based services whenever possible. During the screening the Administrative Agent rules out whether it could provide outpatient services that could maintain the child in the community, avoiding hospitalization. After determining that a child needs hospitalization the Administrative Agent contacts the Admissions Coordinator at Mid-Missouri Mental Health Center. The Admissions Coordinator obtains information about the referral then shares that information with the Child Psychiatrist, who accepts the admission if appropriate and there is a bed available. Unless there is a court order, the

parent/legal guardian must consent to the admission. At the time of admission, written authorizations and consents are obtained.

Although the majority of admissions are voluntary by parent or guardian, occasionally an adolescent is court ordered for inpatient evaluation. An adolescent who is admitted on a 96 hour court commitment may not have gone through an Administrative Agent screening and may not have a parent/guardian present at the time of admission. When a court orders a RSMo. 211.202 DMH evaluation, a DMH protocol is followed in which the Administrative Agent determines whether or not it is most appropriate for the evaluation to be done on an inpatient or outpatient basis. If the Administrative Agent determines that an inpatient evaluation is needed, the Administrative Agent would contact the Admissions Coordinator.

When a child presents at Mid-Missouri Mental Health Center on an unscheduled, emergency basis, MMMHC Policy 11.05.03 is to be followed. The Admissions Coordinator and/or nurse supervisor and a physician do a face to face evaluation of the prospective patient, which will include a mental health screening, assessment of vital signs, physical exam, drug screening and mental status examination. Those patients needing medical emergency services beyond Mid-Missouri Mental Health Center's capabilities are transferred to the University of Missouri Hospital and Clinics Emergency Room. The physician will complete a disposition of evaluation form as outlined in MMMHC Policy 11.05.06.

Criteria for Admission

- 1) The child is between the ages of 6 and 17 years.
- 2) The child is a danger to self or others due to a psychiatric illness.
- 3) The child has severely impaired contact with reality or severely disorganized thinking due to a psychiatric illness.
- 4) The child has a primary diagnosis from Axis I of DSM-IV (TR)
- 5) The child has been screened in an attempt to resolve problems prior to considering inpatient care and it has been determined that inpatient care is the least restrictive environment.
- 6) The admission is court ordered.

Exclusion Criteria.

- 1) The child's primary diagnosis is developmental (for example, Mental Retardation) and the current problems are more appropriately addressed by the MRDD Division of DMH.
- 2) The child's primary diagnosis is substance abuse and the current problems are more appropriately addressed by the ADA division of DMH.
- 3) The child is under 6 or over 17 years of age.
- 4) The referring agency is primarily looking for a place to house the child and there are no current, urgent mental health concerns.

- 5) No effort has been made to evaluate or treat the current problems when warranted on an outpatient basis.
- 6) The child's mental health needs could be met in a less restrictive environment.
- 7) The child's primary problem is delinquency, or the child requires a locked, secure unit solely for the protection of others or for behavior control.
- 8) The child is not medically stable (for example, the child overdosed within the past 24 hours).

Assessment and Evaluation Services.

Evaluation is an ongoing process throughout the child's hospitalization. A Nursing Evaluation and a Biopsychosocial Assessment by the physician are completed as part of the admission process. A Social Service Assessment is also completed on each patient. When possible, the Administrative Agent participates in the admission staffing/assessments by tele-conferencing. Education and Therapeutic Recreation routinely screen all patients; more in depth assessment by these disciplines is done on an as needed basis. Patients are referred for Occupational Therapy or Psychological Assessment/Testing on an as needed basis. Results of individual assessments and ongoing observations of the patient are regularly synthesized by the multidisciplinary team to develop a comprehensive picture of the patient. Evaluation processes routinely include: interview of patient and family/guardian; information from the school; information from other agencies and collateral sources; review of records; standardized testing; and direct observations.

Treatment Modalities.

The unit operates on a multi-disciplinary treatment philosophy. Each child's treatment program is individualized to meet that child's needs. The primary therapist coordinates various treatments, which may include: case management, individual therapy, family therapy, group therapy, medication management, academic education, patient and family education, behavioral programming, occupational therapy and therapeutic recreation. Separate programming and groups are provided for the adolescents and the pre-adolescents. Privileges and/or tangible reinforcers can be earned for positive behavior and active participation in treatment. The core emphases of the program are to teach or develop social, coping and problem solving skills.

The Initial Treatment Plan is developed on admission. It consists of the Biopsychosocial Assessment, the Nursing Assessment, the Nursing Admit Note and the Physician's Admission Orders. The Comprehensive Treatment Plan shall be completed within 72 hours of admission. A Treatment Plan Review is done five days after the Comprehensive Treatment Plan was developed, and weekly thereafter. The treatment team meets daily to discuss each child's treatment and progress; treatment plans are developed and reviewed at this meeting. Parents/guardians receive a copy of the Treatment Plan.

About one week after admission a family meeting/staffing is held. The parent/guardian and Administrative Agent are invited to meet with the treatment team to review the team's assessments of the patient, the treatment plan, the patient's response to treatment, and to plan further treatment, including aftercare. During this meeting, education is provided to parents, including education about diagnoses, medications, and parent intervention strategies. With the parent/guardian's permission, representatives of other agencies working with the child, such as the school or the Juvenile Office, are also invited. If the patient is hospitalized longer than a week, further family meetings/staffings are scheduled as needed.

Discharge Planning.

Since the goal of treatment is to return the child to the community as quickly as possible, discharge planning starts on the day of admission. The social worker coordinates the aftercare plan in discussion with the multidisciplinary treatment team, upon consultation with the patient, parents, the Administrative Agent, and other agencies, with the final approval of the psychiatrist. Aftercare is typically arranged through the Administrative Agent because the Administrative Agents are part of our system of care and because they can provide intensive outpatient services when needed. The aftercare plan is individualized, with the level of intensity of services determined by that child's specific needs. At the time of discharge, the parent/guardian receives an Aftercare Plan that includes the patient's diagnoses, current medications, and initial aftercare appointments. The Administrative Agent also receives a copy of the Aftercare plan and the Discharge Summary. Information from the hospitalization is sent to other involved agencies, with the authorization of the parent/guardian. An Education Termination Report and the Aftercare Plan is sent to the child's school. Records, such as the Discharge Summary or assessments, are sent to other agencies as necessary for the continued treatment of the child.

Discharge Criteria.

- 1) The patient is no longer an imminent danger to self or others.
- 2) If the patient was admitted for impaired reality testing or disorganized thinking, the patient's mental status has stabilized.
- 3) The patient's mental health needs can be met in a less restrictive environment.
- 4) Aftercare that meets the patient's mental health needs has been arranged.